National Institute For Change

We believe that anything can be accomplished by anyone as long as they have the proper guidance and motivation!

The following **Big Ideas** drive our work at NIC:

Expectation: Change *will* happen.

Freedom: Feedback, not failure, is all that exists.

Awareness: Choice is always better than no choice.

Drive: Positive intention is behind every behavior.

Ecology: Every behavior is necessary in some context.

Flexibility: Flexibility and influence are interrelated.

Evolution: Growth requires change.

Connection: Change happens in relationship to another person.

The Plan
(to be completed by intake evaluator)

1st Session

Day: _____

Date: _____

Time: _____

Location: _____

Other Info: _____

_____
(Tear this page off and give to client)

Read the following forms closely and feel free to ask any questions for further clarification. **NIC** exists to serve you in any way we can.

T] 303.231.0090 W] www.nichange.com
F] 303.231.0992 E] change@nichange.com

Aurora
2600 S Parker Road
Building 5 Suite 150
Aurora, CO 80014

Denver
1827 Federal Blvd
Denver, CO 80204

Greenwood Village
9600 E Arapahoe Road
Suite 220
Greenwood Village, CO 80112

Lakewood
3225 S. Wadsworth Blvd
Unit T
Lakewood, Colorado 80227

Enclosed you will find the following forms:

1. Client identification Form
2. Notice of Federal Requirements Regarding Confidentiality
3. Client information and Disclosure Statement
4. Authorization to Release & Receive Confidential Information
5. Clients Rights and Responsibilities
    a. The Grievance Procedure for the Alcohol and Drug Abuse Division
6. Treatment Contract
7. Group Rules
8. Consent to Treat & Consent for Follow- Up Care
9. Audio/Video Recording Consent
10. Pre-Trial/Pre-Sentence Consent
11. Out-of- State Client Questionnaire
12. Medical History
13. Infectious Disease Medical Screen
14. Drinking and Drug History
15. DAST
16. Psychological and Social History

National Institute for Change, P.C.
Client Identification Form

Please provide the following information so we can better serve you (PLEASE PRINT):

Today's Date: _____ Date of Birth: _____

Name: _____
(first) (middle) (last)

Address: _____
(street)

_____
(city) (state) (zip code)

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Is it ok to leave a message at? (check all that apply) ____ Home ____Cell ____ Work ____ Email

Gender:_____ Marital Status: _____ Education: _____ # of Children: ____

Which probation department referred you? _____

Who is your probation or diversion officer? _____

Emergency Contact Name & Phone #: _____

You are the responsible party for payment unless otherwise noted here. If a third party has agreed to pay for your treatment, please check one of the following and provide the **specifics** below:

Probation / Court: _____
Human Services: _____
Other: _____

Do you have Colorado Medicaid? Yes_____ No_____

If so, what is your Medicaid number? _____

Were you ever in the military? Yes _____ No _____

National Institute for Change, P.C.
Notice of Federal Requirements Regarding
Confidentiality Form

The Federal Requirements Regarding Confidentiality of Client Records and Alcohol and Drug Abuse Client Records. National Institute For Change staff follow all state statues and regulation including federal regulation 42 CFR Part 2, and Title 25, Article 4, Part 14 and Title 25, Article 1, Part 1, CRS and the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 142, 160, 162 and 164, governing testing for and reporting of TB, HIV/AIDS, Hepatitis, and other infectious diseases.

National Institute for Change's confidentiality of client records and substance abuse client records maintained by the agency is protected by federal law and regulations. Agency staff is prohibited from disclosing any identifying information about any National Institute for Change client to a person outside the agency, or disclosing that the client in treatment unless one of the following exceptions accrues:

Staff is required to report and or disclose information if and when any of the following occur with any National Institute for Change client:

a. Client consents in writing.
b. Disclosure by a court order.
c. Disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.
d. Client commits or threatens to commit a crime either at the program or against any person who works for the program.
e. A minor or elderly client reports having been neglected and/or abused.
f. Client is planning to harm another person.
g. Client reports suicidal ideations or self-harm.

Violation of this federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

☐ I authorize NIC personnel to communicate with me via email and understand that such communications may not be secure since they involve the internet and applications not within the control of NIC. I understand that it is my responsibility to ensure the confidentiality of the information sent to my email. Furthermore, I understand that information communicated by email will be limited to appointment information and not include clinical information.

Client Name: (please print)_____

Client Signature:_____ Date:_____

Parent/ Guardian Signature: (if applicable)_____ Date:_____

National Institute for Change, P.C.

Client Information and Disclosure Statement

Lakewood (Main Office)
3225 S. Wadsworth Blvd., Unit T
Lakewood, Colorado 80227
Additional Treatment Locations: Aurora, Centennial, Denver

Main Phone: 303-231-0090
Main Fax: 303-231-0992
Main Email: change@nichange.com
Website: www.nichange.com

National Institute for Change, P.C.

We are a professional corporation, co-owned by Philippe R. Marquis, M.A., L.P.C., and Joseph R. Fojut, M.A., L.P.C. All other mental health professionals who provide services at National Institute for Change, P.C. are employees of the corporation, contract employees, or interns and are subject to the guidelines of the corporation and the Department of Regulatory Agencies. Philippe R. Marquis and Joseph R. Fojut are Licensed Professional Counselors. All licensed and registered psychotherapists who are employed by National Institute for Change, P.C and interns of National Institute for Change, P.C. are supervised by Philippe R. Marquis, M.A., L.P.C, and Joseph R. Fojut, M.A., L.P.C.

Philosophy

Your decision to enter psychotherapy is an opportunity to turn a crisis into new understanding, a roadblock into a bridge to the future. We hope that our professional relationship supports your progress by offering an atmosphere of safety, trust, and confidentiality. We accept into our agency only clients who believe they have the capacity to resolve their own problems with our assistance. We believe that as people become more accepting of themselves, they are more capable of finding happiness and contentment in their lives. However, self-awareness and self-acceptance are goals that sometimes take a long time to achieve. Some clients need only a few sessions to achieve these goals, whereas others may require months or even years of psychotherapy and/or psychological services. As a client you are in complete control and may end our professional relationship at any time. When psychotherapy is successful, you should feel that you are able to face life's challenges in the future without our support or intervention.

Mandatory Disclosure

The practice of licensed and registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The Board of Licensed Professional Counselor Examiners and the Board of Registered Psychotherapists can be reached at 1560 Broadway, Suite 1350, Denver, CO, 80202, (303) 894-7800. The practice of licensed social workers is regulated by the Social Workers Examiners Board which can be reached at 1560 Broadway, Suite 1370, Denver, CO, 80202, (303) 894-7766. As to the regulatory requirements applicable to mental health professionals:

✓ Registered psychotherapist is a psychotherapist listed in the State's database and is authorized by law to practice psychotherapy in Colorado but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.

✓ Certified Addiction Counselor I (CAC I) must be a high school graduate, complete required training hours and 1,000 hours of supervised experience.

✓ Certified Addiction Counselor II (CAC II) must complete additional required training hours and 2,000 hours of supervised experience.

✓ Certified Addiction Counselor III (CAC III) must have a bachelors degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience.

✓ Licensed Addiction Counselor must have a clinical masters degree and meet the CAC III requirements.

✓ Licensed Social Worker must hold a masters degree in social work.

✓ Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure.

✓ Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a masters degree in their profession and have two years of post-masters supervision.

✓ A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision.

In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.

You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy (if known), and the fee structure. You can seek a second opinion from another therapist or terminate therapy at any time.

Confidentiality

Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality, some of which are listed in section 12-43-218 of

the Colorado Revised Statutes, and the HIPAA Notice of Privacy Rights you were provided, as well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report suspected child abuse to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly. The Mental Health Practice Act (CRS 12-43-101, et seq.) is available at: http://www.dora.state.co.us/mental-health/Statute.pdf. Some other examples are:

• We are required by law to report suspected child abuse and/or neglect without an investigation to the proper authorities, who may then investigate.
• We may take some action without your consent if we deem you to be a serious harm to yourself or another.
• If you file an official complaint or a lawsuit against one of our therapists, according to Colorado law, your right to confidentiality will be waived.
• If you choose to use your health benefit plan, you will have to give consent for required confidential information to be given to your insurance company or managed care company for the purpose of determining eligibility for reimbursement.

Fees

This time is reserved for you. **You are responsible for payment at the time of each session**. We must receive cancellation 24 hours before your scheduled appointment time; otherwise you will be charged for that session. We do not accept personal checks as a form of payment. If we are unable to collect our agreed upon fee after 90 days when the service was provided, we may send your name and address to a collection agency or seek collection with a civil court action. Should this occur, we will provide the collection agency or Court with your Name, Address, Phone Number, and any other directory information, including dates of service or any other information requested by the collection agency or Court deemed necessary to collect past due account.

Health Care Benefits

In the event that you choose to use your health care benefits and our services are reimbursable under your insurance plan, you will have to give us consent to release required information. Released confidential information may range from identifying information, diagnosis, and dates of sessions to a complete assessment with treatment goals and progress reports when your benefits fall under managed care. We cannot be in control of the storage of confidential information nor access to your confidential information when it is given to a third party. The insurance company will determine benefit coverage and the kind of service for which they will reimburse. We will discuss with you my recommendations for treatment, and you will decide how you want to proceed.

Emergency Contacts

For immediate help, call 911 or go to your local Emergency Room. You can also contact the Colorado Crisis Line at 1-844-493-8255.

Termination

Termination will usually be agreed upon mutually, but you are free to terminate at any time. However, in a few special circumstances the decision to discontinue treatment may be made, even though you wish to continue. These circumstances may include, but are not limited to, a failure to meet the terms of the fee agreement, or a need for special services outside the area of our competency. Should this occur, the reason for termination will be discussed with you, and you will be helped to make different plans for yourself, including a referral to a more appropriate resource (s). Additionally, in the event a client discontinues contact with NIC for 30 days or longer, he/she will be considered discharged from treatment at NIC.

I have read the preceding information, it has also been provided verbally, and I understand my rights as a client, or as the client's responsible party.

Client Name: (please print) _____

Client Signature: _____ Date: _____

Parent/ Guardian Signature: (if applicable) _____ Date: _____

Staff Signature: _____ Date: _____

National Institute for Change, P.C.

Client Information and Disclosure Statement ADDENDUM

Staff Degrees & Credentials:

Tim Carlson. M.A. in Clinical Mental Health Counseling from Denver Seminary, 2021; Licensed Professional Counselor Candidate (LPCC #18833 issued in CO 8-24-2021); DVOMB Approved Provider.

Joseph R. Fojut, M.A. in Community Counseling from University of Northern Colorado, 2004; B.S.W. in Social Welfare from Criminal Justice from University of Wisconsin at Milwaukee, 1995; Licensed Professional Counselor (LPC #4689 issued in CO 6-26-2007), DVOMB Approved Clinical Supervisor and Provider.

Alina Galushko, M.A. in Counseling Psychology & Counselor Education from University of Colorado Denver, 2010; B.S. in Psychology from Colorado State University, 2007; Licensed Professional Counselor (#0011207 issued in CO 10-01-2012); Licensed Addiction Counselor (#0000623 issued in CO 10-02-2015), DVOMB Approved Provider.

Jordan Herselman, M.A. in Clinical Mental Health Counseling from Denver Seminary, 2016; Licensed Professional Counselor (#0015116 issued in CO 1-8-2019), DVOMB Approved Provider, Licensed Addictions Counselor, (#0001256 issued in CO 5-24-2019).

Lydia Hoffmann, M.A. in Clinical Mental Health Counseling from Denver Seminary, 2018; B.S. in Psychology, Addiction and Recovery from Liberty University, 2015. Licensed Professional Counselor (#16962 issued in CO 3/21/2021). DVOMB Approved Provider.

Amanda N. Hua, MA, Colorado Christian University. EMDR, DVOMB Approved Provider, Licensed Professional Counselor (#16056 issued 2/11/2020).

Julia Kuczkowski, M.A. in Clinical Mental Health Counseling from Denver Seminary, Addiction Counselor Candidate (#101 issued in CO 2021), Licensed Professional Counselor Candidate (#18015 issued in CO 2021).

Kevin LaPoint, M.A. in Counselor Education from Adams State University,2015; PhD in Sociology from University of New Mexico, 2009; Licensed Profession Counselor (LPC #0014085), DVOMB Approved Provider, Certified Addictions Counselor II, (#0008382 issued in CO 7-5-2018).

Philippe R. Marquis, M.A. in Community Counseling from University of Northern Colorado, 2001;B.S. in Human Services from Metropolitan State College, 1995; Licensed Professional Counselor (LPC #4429 issued in CO 8-25-2006), DVOMB Approved Clinical Supervisor and Provider; Licensed Addiction Counselor (#1025 issued in CO 5/16/2018).

Olivia Magnuson, M.A. in Clinical Mental Health Counseling from Denver Seminary, 2019; Registered Psychotherapist (#109061 issued in CO 9/27/2018); Licensed Professional Counselor (LPC #17792 issued in CO 11/29/2021).

Amanda Murphy; M.A. in Counseling from Colorado Christian University, 2017; B.S. in Psychology from Clarke University, 2015; Licensed Professional Counselor (#16249 issued in CO 5/13/2020); Licensed Addiction Counselor (ACD.0001658 issued in CO 2/11/2021); DVOMB Approved Provider.

Samantha Rossman, M.Ed in Counseling Psychology 2020; B.S. in Psychology from University of Akron 2017. Licensed Professional Counselor Candidate (#17600 issued in CO 5/21/20).

Amelia (Ame) Smith, M.A. in Forensic Psychology from University of Denver, 2017; B.A. in Psychology and Business Administration from Coe College, 2015; Licensed Professional Counselor (LPC #16253 issued in CO 9/1/2021); DVOMB Approved Provider.

NIC also utilized interns and volunteers for some services, their information is available upon request.

NATIONAL INSTITUTE FOR CHANGE, P.C.

Release of Information Form

Authorization for Use or Disclosure of Protected Health information

1. Release of Information:
   a. □ I hereby authorize National Institute for Change to **DISCLOSE** protected information to the following organization/person (s) as described below:
   b. □ I hereby authorize National Institute for Change to **RECEIVE** protected information from the following organization/person (s) as described below:

Organization/Name: _____	Organization/Name: _____
Phone/Fax: _____	Phone/Fax: _____
Email/Address: _____	Email/Address: _____

2. I hereby authorize release of the following information (please check all that apply):

□ Treatment	□ Evaluation Results	□ Treatment Attendance
□ Clinical Progress	□ Employment	□ Lab Results
□ Criminal Records	□ Treatment Planning	□ Monitoring Compliance
□ Payment Information		
□ Medication Assessment and Management (including Medical Marijuana)		

3. This authorization shall be in force and effect until _____ or for 1 year after discharge at which point this authorization will expire.

4. I understand I have the right to revoke this authorization, in writing, at any time. I understand that revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization.

5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that my records are protected under the Federal Regulations governing Confidentiality of Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This consent automatically expires at the end of one year unless otherwise indicated below.

Client Name (print):

Client Signature: _____ Date: _____

Parent/ Guardian Signature: (if applicable) _____ Date: _____

Staff Signature: _____ Date: _____

I hereby revoke this authorization effective _____

Client Signature: _____ Date: _____

Staff Signature: Date:

NATIONAL INSTITUTE FOR CHANGE, P.C.

****DUI INTAKES ONLY****

Release of Information Form

Colorado State statutes governing DUI Treatment in the state of Colorado dictate that your attendance and compliance in DUI Education and/or Treatment be reported to supervising agencies, including the Department of Motor Vehicles and probation departments. This is accomplished through the DUI Reporting System (DRS).

1. Release of Information:
   a. □ I hereby authorize National Institute for Change to **DISCLOSE** protected information to the following organization/person (s) as described below:
   b. □ I hereby authorize National Institute for Change to **RECEIVE** protected information from the following organization/person (s) as described below:

Organization/Name: Department Of Motor Vehicles

2. I hereby authorize release of the following information (please check all that apply):
   □ Treatment Compliance/Attendance □ Reporting Agency/Supervising Officer
   □ Identifying Information □ Treatment Requirements
   □ Court Information

3. This authorization shall be in force and effect until _____ or for 1 year after discharge, at which time this authorization expires.

4. I understand I have the right to revoke this authorization, in writing, at any time. I understand that revocation will result in DMV being notified of my withdrawal from treatment.

5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that my records are protected under the Federal Regulations governing Confidentiality of Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This consent automatically expires at the end of one year unless otherwise indicated below.

Client Name (print):

Client Signature: Date:

Parent/ Guardian Signature: (if applicable) Date:

Counselor Signature: Date:

National Institute for Change, P.C.
Client Rights and Responsibilities

As a client of NATIONAL INSTITUTE FOR CHANGE, you have the right to:

A. Access to treatment that is free from discrimination by race, religion, ethnicity, age, handicap, sex, sexual orientation, and/or gender identity.

B. Care and treatment which recognizes and respects your personal dignity at all times.

C. Individualized treatment which includes adequate and humane services, least restrictive environment, and individual treatment plan.

D. To be informed of the adequate training and certification of the staff implementing your treatment.

E. Personal privacy within the constraints of your treatment in accordance with all state and federal confidentiality rules and regulations.

F. To have the right to view and obtain copies of a summary mental health record pertaining to your individual treatment. A summary record is the date of your first contact, the presenting problem, a treatment plan if one is developed, progress made, and the dates of attendance including last contact.

The Grievance Procedure for the Alcohol and Drug Abuse Division
If you believe that your rights as a client have been violated, the following procedure should be followed: First, discuss the matter with your therapist. If the matter is not resolved, then contact the Clinical Director, Joseph Fojut at 303-231-0090 x 103 to discuss the issue further. If the matter is still not successfully resolved, then contact the appropriate Licensing Board listed on the Disclosure form. If the matter involves the Substance Abuse/DUI programs, then contact the Division of Behavioral Health, Colorado Department of Human Services, 3824 West Princeton Circle, Denver, CO 80236-3111, (303) 866-7400. If not, contact the State Grievance Board, 1560 Broadway, Suite 870, Denver, CO 80202 or at 303-894-7766.

As a client of NATIONAL INSTITUTE FOR CHANGE, you are responsible for:

A. Actively participate in your individual treatment and adhere to treatment contract regarding your attendance and financial obligations.
B. Report changes in your condition to your therapist.
C. Be considerate and respectful of the rights of other clients as well as all NIC staff.
D. Honor the confidentiality of other clients.
E. Keep appointments and cooperate with staff.
F. Keep your agreements with NIC.
G. Be honest about matters that relate to you as a client and to your treatment.
H. Attempt to understand why you have been referred to treatment.

Client Name (print): _____

Client Signature : _____ Date: _____

Parent/ Guardian Signature: (if applicable) _____ Date: _____

National Institute for Change, P.C.

Treatment Contract

I agree to the following stipulations:

1. I will be non-violent for the duration of counseling. This includes engaging in psychological, verbal, physical, or sexual violence. These types of violence include, but are not limited to: name calling, belittling; threatening; swearing; intimidating; grabbing; restraining; pushing; hitting; sexual assaulting or harassing; choking; breaking my own or other's property; and the like (5.05, II A, 1).

2. I will not consume any psychoactive substances for a period of 24 hours before a therapy session. I also agree that I will not bring any drug or alcohol paraphernalia to therapy. I realize that attending any therapy session under the influence of substances may lead to monitored Antabuse, drug and/or alcohol screens, or additional treatment, and / or termination from treatment at the discretion of your clinician (5.05 II, A, 3). I also understand that I am responsible for payment of drug screens if I am required to submit a drug screen for any reason.

3. I agree to enter chemical dependency treatment if recommended by National Institute for Change, P.C. staff or probation. This recommendation may occur at any point in treatment. I do realize that I am responsible for any additional treatment costs. (5.05 II, A, 3).

4. I agree to be evaluated for chemical dependency problems or other psychiatric problems when recommended by National Institute for Change, P.C. staff or probation. This recommendation for evaluation may occur at any point in treatment. I do realize that I must pay for any ongoing evaluation or additional treatment.

5. I agree to attend all counseling sessions. Three total absences – whether excused or unexcused, or two absences in a row, will lead to termination or extension of the counseling program (5.05 II, B, 7 and C, 1-2).

6. Unexcused absences must be paid for by the client. Excused absences will not be charged for by the counselor. Excused absences are only given for illness of self or family member (with doctor's note), death of family member, court date conflicts, or incarceration. You may be excused for vacation, but this must be arranged for at least two weeks in advance and must have approval of both the counselor and probation officer. These are the only situations that will be accepted for an excused absence. All excused absences must have written documentation by the proper authorities (5.05 II, B, 7).

7. Payment for treatment is due at the time of each session, unless previously arranged for, with the counselor. I understand that I will not be allowed to enter a session without a payment and it will be counted as an unexcused absence.
8. I agree to pay for all treatment costs. Including, but not limited to the fee for the evaluation and treatment. I also understand that all balances carried throughout the month MUST be PAID IN FULL at the end of the month (5.05 II A, 2). Balances over $75 dollars will not be tolerated. If my balance is this amount or over, I must meet with my counselor, complete and comply with a Financial Agreement Form, and bring my balance below $75. If I fail to comply, I understand I will be terminated.

9. I understand the cost of an Evaluation ranges from $250 to $350 per evaluation, Domestic Violence intake evaluations are $125, non-domestic violence outpatient intakes are $70 and group treatment services are $35 to $40 per group session. A sliding fee scale is available for services for those who qualify (5.05 II, A, 2 and 5.05 II B, 2 & 9).

10. I understand the court's requirements for treatment, including my financial responsibilities for treatment. I agree in the case of non-payment for services, I will be responsible for all court costs, attorney fees, collection fees, counselor fees, and staff fees in order for National Institute for Change, P.C. to receive any amounts owed.

11. I agree to participate in treatment by verbalizing thoughts, expressing feelings, and completing all homework assignments.

12. I understand that absences shall be reported to the victim advocate and probation officer/case worker within 24 hours of the absence. The treatment victim advocate will determine if the victim shall be notified according to the advocacy (5.05, II C, 3).

13. If enrolled in Domestic Violence treatment, I agree to not purchase or possess firearms or ammunition. An exception may be made if there is a specific court order expressly allowing the offender to possess firearms and ammunition. In these cases, it is incumbent upon the offender to provide a copy of the court order to their therapist to qualify for this modification of the offender contract and a treatment plan will be developed to address storage of the firearm. (5.05 II, A - 8).

14. I agree to not bring any weapons to treatment, including but not limited to firearms, knives or other threatening objects.

15. I agree to not violate any criminal statutes or ordinances (city, county, state, or federal), comply with existing court orders regarding family support, and comply with any existing court orders concerning a proceeding to determine paternity, custody, the allocation of decision making responsibility, parenting time, or support (5.05, II, A 5-7).

16. If enrolled in Domestic Violence treatment, I agree **NOT** to participate in *any* couple's counseling or family counseling while in treatment. This includes any joint counseling that involves the offender and victim (5.05, II, A 9).

17. I understand that suspected child abuse will be reported by National Institute for Change, P.C. staff.

18. I understand that confidentiality will be kept, except when it is judged that I am a danger to self or others, or if I become gravely disabled. Adequate steps to insure the safety of all parties involved will be taken. I further understand and have been advised that my right to confidential communications is not absolute and in addition to the above exceptions, NIC may use confidential information in the event of responding to a lawsuit or other adverse action by a court, regulatory body, or hospital health care panel (5.05, II, B 1)

19. Domestic violence offenders agree that offender waivers of confidentiality shall also extended to the victim, specifically with regard (1) the offender's compliance with treatment and (2) information about risk, threats, and/or possible escalation of violence (5.05, II, B 1).

20. I agree to sign all release forms deemed necessary for treatment at NIC (5.05 II, A 4).

21. I agree to complete all intake paperwork in full. Failure to do so will prevent me from entering into treatment at National Institute for Change, P.C. Included in the paperwork is a disclosure statement and client's rights that I have read and signed (5.05, II, B 3).

22. I understand that the intensity, duration, and level of treatment is unknown at this time but I will be informed after the evaluation is completed (5.05, II, B 5).

23. I understand the National Institute for Change does not offer 24-Hour crisis services. If I need emergency services I will call 9-1-1 or Colorado Crisis Services 1-844-493 (TALK) or www.ColoradoCrisisServices.org (5.05 II, B 4).

24. I have been informed that the approved DVOMB provider may have files reviewed for the purposes of processing new applications and the biennial renewal (5.05, II, B 8)

25. I agree to arrive 15 minutes prior to my scheduled session time, in order to facilitate check-in procedures.

26. If an exception is made, and you are allowed to pay by check, there will be a $20 service charge for all returned checks, each time they are returned.

27. I am responsible for informing National Institute for Change, P.C. staff, at least one week in advance, of the need for documentation for any court proceeding, or meeting with my probation officer. This notification of the need for paperwork must be in written form to the counselor. All documentation must be delivered by the client to the appropriate person.

28. I understand that violations of this offender contract or noncompliance with the treatment plan may lead to termination from the program. At a minimum, written or verbal notification of the violation shall be provided to the MTT. Notifications of the violations or noncompliance will be provided to law enforcement and / or courts, when appropriate. Violations of the offender contract may include exhibiting signs of imminent danger to others or escalating behaviors that may lead to violence (5.05 II D).

29. The Grievance Procedure for Domestic Violence Division. If you believe that your rights as a client have been violated, the following procedure should be followed; First, discuss the matter with your therapist. If the matter is not resolved, then contact the Executive Manager, Diane Keeling at 303-231-0090 to discuss the issue further. If the matter is still not successfully resolved, then contact the appropriate Licensing Board on the Disclosure Form.

Client Name (print): _____

Client Signature: _____ Date: _____

Parent/ Guardian Signature: (if applicable) _____ Date: _____

Therapist Signature: _____ Date: _____

National Institute for Change, P.C.
Treatment/Group Rules

I agree to abide to the following rules:

1. I understand and will comply with the policies for excused and unexcused absences.

2. I will not be late for group sessions. I understand that coming to group more than ten minutes late will result in my attendance being counted as 'unexcused' and I will have to pay for the session.

3. I understand the policies on attending sessions while using mood altering substances. If the counselor suspects that I have ingested substances prior to a session, I agree to not participate in that session.

4. If I admit to having used alcohol or drugs, I will be asked to sit out that session, will be assessed an unexcused absence and my probation officer will be notified.

5. I realize that attending any group under the influence of substances, may lead to monitored Antabuse, drug and/or alcohol screens, or additional treatment, and / or termination from treatment. I also understand that I am responsible for payment of drug screens if I am required to submit a drug screen for any reason.

6. I agree to respect confidentiality of therapy sessions. I understand the limits of confidentiality outlined in the Treatment Contract. In furtherance of respecting groups/individuals/evaluations confidentiality, I agree not to use or encourage the use of texting, audio, video, or any other electronic recording of a group, individual, or evaluation sessions or any part thereof. My failure to comply with confidentiality will result in termination from treatment.

7. If I have contact with a member of the group outside of this group, we will not discuss confidential information outside of this group.

8. I will be non-violent inside and outside of group. If I bring any weapons to the group, the authorities will be notified immediately and I will be terminated.

9. I will not threaten group members or staff, either physically, verbally or in any manner. Any threats will result in police being called and probation being notified.

10. I will not smoke, chew tobacco, eat or read books, newspapers or magazines during group session.

11. I will not leave children unattended in the waiting room during group/individual sessions.

Client Name (print): _____

Client Signature: _____ Date: _____

Parent/ Guardian Signature: (if applicable) Date:

National Institute for Change, P.C.

Consent to Treat

I consent to such evaluation and treatment as the professional staff of National Institute for Change may decide. I am aware that care and treatment in this area is not an exact science. I acknowledge that no guarantees have been made to me as to the result of treatment and evaluation at National Institute for Change and I have been advised of the potential risks and benefits of treatment. I certify that I have read and fully understand the contents of this form and that all statements are true to the best of my knowledge.

Client Name (print):

Client Signature: Date:

Parent/ Guardian Signature: (if applicable) Date:

National Institute for Change, P.C.

Consent for Follow-Up Contact

I hereby grant permission to the administrative and/or research staff of National Institute for Change, P.C. to contact me, after my discharge from National Institute for Change, to obtain information for research purposes only. All information will be considered confidential. I may revoke this consent at any time. It will automatically expire at one year from discharge.

Client Name (print):

Client Signature: Date:

Parent/ Guardian Signature: (if applicable) Date:

AUDIO/VIDEOTAPE RECORDING CONSENT FORM

I understand that the counseling sessions provided to me, _____ (First & Last Name) by his/her counselor(s) may be recorded via audio/video tape in order to supervise and evaluate the counselor. I further understand that confidentiality of all recorded sessions will be maintained. Only the counselor and his/her supervisor and/or clinical team will have access to the recorded sessions.

I understand that the recorded sessions may be reviewed by other counselor trainees for instruction purposes only.

Additionally, I understand that the audio/video will be deleted and cannot be subpoenaed or released after 30 days to anyone including myself.

My signature below indicates my understanding of and consent for recording sessions

Name: _____ Date: _____

Signature: _____ Date: _____

Pre-Trial/Pre-Sentence Clients:

The customary and typical therapeutic obligations and assurances of confidentiality do not exist in a forensic context. NIC may be contacted to release confidential communications to the Court, Officers of the Court, Department of Corrections or Jail Services (including Probation and Parole), or any Law Enforcement agency, during or after completion of an evaluation or treatment.

Furthermore, any treatment report or evaluation may be used in a legal proceeding and the report or evaluation may be used as evidence against you as well as any other information that was provided concerning your mental health and functioning.

DVOMB Standards:

4.07 Pre- and Post-Sentence Evaluation Purposes:
I. Evaluation(s) shall not be used to determine guilt or innocence, or whether or not an act of domestic violence has occurred as the offender has already pled guilty to, or has been convicted of a domestic violence offense.
II. Evaluation(s) shall be conducted to identify the following factors: risk of re-offense and/or further abuse, offender criminogenic needs, offender responsivity to treatment, and other treatment issues as identified in Section 4.08 "Required Minimum Sources of Information." These factors shall assist in determining recommendations regarding offender treatment.
III. Evaluation(s) shall be used to develop baseline measures in order to assess offender gain or deterioration with regard to criminogenic need and risk of re-offense.
IV. Evaluation(s) shall result in an initial offender Treatment Plan with the understanding that assessment is an ongoing process, which may necessitate changes to the plan.

V. Evaluation(s) shall direct initial placement of the offender into the appropriate level and intensity of treatment as identified in Standard 5.06.
As a Pre-Trial / Pre-Sentence client I am also acknowledging that the treatment that I enroll and participate in until my trial may not be counted towards probation requirements for treatment. Treatment Plan Reviews completed prior to post-sentencing may not be recognized by the Multidisciplinary Treatment Team (MTT), consensus must be met by all members of the MTT.

I acknowledge that I have been advised of the above disclosures and the potential for adverse consequences to my judgment at trial or subsequent sentence. As a Pre-Trial/Pre-Sentence Client, I hereby authorize NIC to disclose any and all information pertaining to my evaluation or treatment to the aforementioned agencies or their representatives upon request.

_____
Name of Client (print)

_____
Client Signature Date signed

_____
Parent/Guardian Signature (if applicable) Date Signed

_____
Witness/Treatment or Evaluation provider Date Signed

National Institute for Change, P.C.
Out-of-State Client Questionnaire

The following questions must be answered by all clients seeking admission to this program and are required by Colorado law. Refusal to cooperate, or failure to provide complete or accurate information, including failure to sign a release of information to the referring criminal justice agency, will result in immediate discharge from the treatment program and notification of authorities.

1) Are you applying for treatment because of a current requirement to attend a treatment program in Colorado by any court, department of corrections, state board of parole, probation department, parole division, adult diversion program, or any other similar entity or program **in another state**?

   Yes _____ **No** _____

IF Yes, please provide the following information:
Probation Officer, Parole Officer, Judge and / or Diversion Officer's:

Name: _____

Address: _____

Phone: _____
IF Yes, please answer the following question:

2) Are you, or will you be, under the supervision of a probation officer or parole officer in Colorado?

Yes _____ **No** _____

Note: If you do not have an assigned Colorado probation or parole officer, the Interstate Compact Office will be notified.

3) For DUI offenders ONLY: Are you seeking education or treatment for the sole purpose of restoring your driving privileges as the result of an alcohol or drug related driving offense in another state but <u>are not under a court order</u> to do so?

Yes _____ **No** _____

Social Security Number: _____ Place of Birth: _____

Client Name (print): _____

Client Signature: _____ Date: _____

Parent/ Guardian Signature: (if applicable) _____ Date: _____

National Institute for Change, P.C.
Client Medical History

13. Do you have an Advanced Directive? **Yes** _____ **No** _____

Adverse Childhood Experience (ACE) Questionnaire

1) Did a parent or other adult in the household **often…** (check if yes) ☐
   a) Swear at you, insult you, put you down, or humiliate you?
   b) Act in a way that made you afraid that you might be physically hurt?
2) Did a parent or other adult in the household **often…** (check if yes) ☐
   a) Push, grab, slap or throw something at you?
   b) **Even** hit you so hard that you had marks or were injured?
3) Did an adult or person at least 5 years older than you **ever…**(check if yes) ☐
   a) Touch or fondle you or have you touch their body in a sexual way?
   b) Try to or actually have oral, anal, or vaginal sex with you?
4) Did you **often** feel that… (check if yes) ☐
   a) No one in your family loved you or thought you were important or special?
   b) Your family didn't look out for each other, feel close to each other, or support each other?
5) Did you **often** feel that… (check if yes) ☐
   a) You didn't have enough to eat, had to wear dirty clothes, and had no on to protect you?
   b) Your parents were too drunk or high to take care of you or take you to the doctor if you needed?
6) Were your parents **ever** separated or divorced? (check if yes) ☐
7) Was your mother or stepmother: (check if yes) ☐
   a) **Often** pushed, grabbed, slapped, or had something thrown at her?
   b) **Sometimes or often** kicked, bitten, hit with a fist, or hit with something hard?
   c) **Ever** repeatedly hit over at least a few minutes or threatened with a gun or knife?
8) Did you live with anyone who was a problem drinker, alcoholic or who used street drugs? (check if yes) ☐
9) Was a household member depressed or mentally ill or did a household member attempt suicide? (check if yes) ☐
10) Did a household member go to prison? (check if yes) ☐

Total number of "yes" answers: _____

The Drug Abuse Screening Test (DAST)

Directions: The following questions concern information about your involvement with drugs. Consider the past year (12 months) and carefully read each statement. Then decide whether your answer is YES or NO and check the appropriate space. Please be sure to answer every question.

	YES	NO
1. Have you used drugs other than those required for medical reasons?	___	___
2. Have you abused prescription drugs?	___	___
3. Do you abuse more than one drug at a time?	___	___
4. Can you get through the week without using drugs (other than those required for medical reasons)?	___	___
5. Are you always able to stop using drugs when you want to?	___	___
6. Do you abuse drugs on a continuous basis?	___	___
7. Do you try to limit your drug use to certain situations?	___	___
8. Have you had "blackouts" or "flashbacks" as a result of drug use?	___	___
9. Do you ever feel bad about your drug abuse?	___	___
10. Does your spouse (or parents) ever complain about your involvement with drugs?	___	___
11. Do your friends or relatives know or suspect you abuse drugs?	___	___
12. Has drug abuse ever created problems between you and your spouse?	___	___
13. Has any family member ever sought help for problems related to your drug use?	___	___
14. Have you ever lost friends because of your use of drugs?	___	___
15. Have you ever neglected your family or missed work because of your use of drugs?	___	___
16. Have you ever been in trouble at work because of drug abuse?	___	___
17. Have you ever lost a job because of drug abuse?	___	___
18. Have you gotten into fights when under the influence of drugs?	___	___
19. Have you ever been arrested because of unusual behavior while under the influence of drugs?	___	___
20. Have you ever been arrested for driving while under the influence of drugs?	___	___
21. Have you engaged in illegal activities in order to obtain drug?	___	___
22. Have you ever been arrested for possession of illegal drugs?	___	___
23. Have you ever experienced withdrawal symptoms as a result of heavy drug intake?	___	___
24. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	___	___
25. Have you ever gone to anyone for help for a drug problem?	___	___
26. Have you ever been in a hospital for medical problems related to your drug use?	___	___
27. Have you ever been involved in a treatment program specifically related to drug use?	___	___
28. Have you been treated as an outpatient for problems related to drug abuse?	___	___

A score of "1" is given for each YES response, except for items 4, 5, and 7, for which a NO response is give a score of "1."

Total Score: _____

The Alcohol Use Disorders Identification Test (AUDIT)

Instructions: *Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Please* ***circle*** *the box that best describes your answer to each question.*

Questions:	0	1	2	3	4
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year
					Total Score:

National Institute for Change, P.C.
Infectious Diseases Medical Screen

Client Name (print): _____

Please mark most accurate response to each question. These answers will be shredded and only the scoring sheet will remain in your file.

1. Have you been a recipient of a blood transfusion or organ transplant prior to 1992 (includes receiving blood during birth or other surgical procedures)? **Yes** _____ **No** _____

2. Have you ever been or are you now on long-term hemodialysis (blood cleansing)?
Yes _____ **No** _____

3. Are you a recipient of clotting factor made prior to 1987? **Yes** _____ **No** _____

4. Have you ever been stuck by a needle or anything sharp that was likely to have been contaminated with hepatitis C-infected blood? **Yes** _____ **No** _____

5. Were you born to a mother who had hepatitis? **Yes** _____ **No** _____

6. Have you ever had symptoms of liver disease or abnormal liver function / enzyme tests?
Yes _____ **No** _____

7. Have any of your sexual partners been infected with hepatitis B or C?
Yes _____ **No** _____

8. Have you been the recipient of tattooing or body piercing in unsanitary conditions (e.g. unsterile needles)?
Yes _____ **No** _____

9. Mark all of the following that currently apply to you or that applied to you in the past.
   - Close contact with active TB
   - Treated for TB
   - Have had an abnormal chest X-ray
   - Have had a positive TB Test

Have you ever been diagnosed with any of the following medical conditions?

   - HIV
   - Diabetes
   - Silicosis
   - Black lung or coal miner's disease
   - Bleeding/clotting disorders
   - Specific malignancies (cancerous tumors that speed throughout the body)
   - Kidney Failure
   - Any other immune disorders

10. Have you ever spent time in Africa, Asia, Latin America, Eastern Europe or Russia? **Yes ____ No ____**

11. Have you ever been employed as a health care worker or volunteer who served high-risk clients?
Yes _____ No _____

12. Have you ever been a resident or employee/volunteer at a:

- Correctional Facility
- Nursing Home
- Mental Institution
- Homeless Shelter
- Residential treatment facility
- Transitional living facility

13. Mark all that apply currently or in the past:

- Have had a cough for more than 3 weeks
- Have coughed up blood/colored mucous
- Swollen, non-tender lymph nodes (at the base of the jaw or neck)
- Prolonged loss of appetite
- Unexplained weight loss of 10 pound or more
- Recurrent fevers or heavy night sweats for more than 3 weeks

14. Have you had multiple sexual partners (more than one)? **Yes _____ No _____ (5 point)**

15. Have you ever had anal sex? **Yes _____ No _____ (10 points)**

16. How often do you use protection (condoms, etc.) when having sex?
Never _____ (10 points) **Sometimes _____ (5 points)** **Always _____(0 points)**

17. Have you used needles to inject any substance in your body? **Yes _____ No _____ (10 points)**

18. Do you know or suspect that your sexual partners ever injected any substance with a needle?
Yes _____ No _____ (5 points)

19. Have you or any of your sexual partners ever had: (mark all the following that currently apply to you or your sexual partners) (**5 points per response)**

- Gonorrhea
- Syphilis
- Chlamydia
- HPV or Genital Warts
- Genital Herpes
- Cervical Cancer

*********Shred Pages 29 and 30***********

Response Guide:

If you answered "yes" to any question # 1-7, please see your counselor for a referral to be screened for hepatitis B and C.

If you answered "yes" to question # 8, please see your counselor for a referral for infectious disease screening and testing.

If you answered "yes" to any of the categories in question # 9-12 , please see your counselor for a referral to be screened for tuberculosis.

If you answered "yes" to any part of question 13, this indicates high risk for active TB or TB infection, HIV, and Hepatitis. Please see your counselor for a referral to a healthcare practitioner or health department for testing/treatment.

If you answered "yes" to any question # 14-19, total the corresponding numeric values: **Total Score: _____**

Scoring Guide:

0-20 Low Risk for acquiring/transmitting HIV
25-40 Medium Risk
45-75 High Risk

The following referrals have been provided:
__ Tri-County Health Department: 303-341-9370
__ Denver Health: 303-602-8710

The state requires Office of Behavioral Health licensed treatment agencies to offer and discuss HIV/Hepatitis and TB testing services. If these services have been offered, please acknowledge by signing below.

Client Name (print): _____

Client Signature: _____ Date: _____

Parent/ Guardian Signature: (if applicable) _____ Date: _____

Counselor Signature: _____ Date: _____